MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Friday, March 21, 2003
9:03 a.m.

COMMISSIONERS PRESENT:

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AGENDA ITEM:

Using incentives to improve quality in Medicare
-- Karen Milgate, Sharon Cheng

MR. HACKBARTH: First on our agenda this morning is using incentives to improve quality of care. Karen?

MS. MILGATE: Good morning.

This discussion is the third discussion we've had on this, although the first two were more in the form of introduction to the topic. And we will have one final conversation next month, in April. This is in preparation for a chapter that will be in our June report on using incentives to improve quality in Medicare.

In April, we anticipate bringing back some further analysis of how incentives might work in specific settings or types of care. So a little bit more drilling down.

Today, though, what we'd to cover in our presentation and then are really looking forward to the conversation afterwards, is just summing up what Medicare is currently doing with incentives to improve quality findings from a set of interviews we have done with a broad spectrum of private sector purchasers and plans. And then finally, having some discussion of how what we learned from the private sector might be able to be applied in the Medicare program.

Quickly, as we've talked about this in previous discussions, why are we talking about this? Why are incentives important? And why are so many different folks in the press and in journals talking about incentives for quality?

Current health system payment and other mechanisms are currently neutral or negative towards quality. This comes in several different forms.

In Medicare, the payment essentially does not differentiate between a high quality or a low quality product. Basically, all products are paid the same in terms of the DRG payments and other payments for providers. And sometimes, even there's higher payment for lower quality, such as the case in if there are complications due to errors in procedures that someone might -- a hospital might actually get a higher DRG if there's a lower quality product.

In addition to the payment mechanisms, you also don't have the same kind of markets working, in terms of consumers having information where they can really drive the market to higher quality product. Either good information doesn't exist for consumers, or there's also a tendency, at least for the information that's out currently, for consumers not to use the information that's out there, or to think it's particularly useful for their purposes. So private and public purchasers are looking to other incentives to improve quality.

Medicare program currently does use a fair amount of incentives. CMS has been fairly aggressive in their efforts in this area. They use flexible oversight, and one example of that

is in the M+C program. They allow M+C plans that reach a certain level of mammography screening not to have to perform one of the national quality projects which are required through the M+C regulations.

One of the other efforts that they're undertaking is public disclosure of information on specific settings of care. They've done this now for the Medicare+Choice plans, dialysis. The most recent setting was nursing homes. They also now have pilots in the home health area and have a voluntary program, at least, in the hospital area and hoping to expand that later on.

In addition to that, they are also looking to demonstrate different types of payment mechanisms. There's two, in particular, that we felt when we talked to CMS, really fell into the area of incentives. And that was a shared savings demo. They don't call it that. They call it the Physician Group Practice demo.

Essentially, what it does is it's an attempt to calculate expected expenditures for certain types of beneficiaries with chronic conditions. First is actual, and then if there are savings to distribute those savings at least in part to the physician group practices. So, for example, if there's lower hospitalizations, to be able to capture some of those savings and give it back to the docs who put the guidelines and protocols in place that both improve quality and save dollars.

The other one we wanted to highlight was a disease management demo. In contrast to how disease management is current paid, which is usually on a fee-for-service basis, it would be a capitated payment to the disease management organization. And it could be a variety of different organizations. So this isn't the business of disease management. It could be a provider, it could be a variety of folks. With the concept being that paying on the basis of capitation would give incentives to the organization to better manage care across settings.

Other initiatives that CMS is undertaking also feed into incentives. They help build the infrastructure that we found that so necessary in the private sector to actually be able to put in place financial incentives. One way they do this is through the QIO program, where they provide feedback to hospitals and feedback to physicians on their performance and try to get them to improve themselves. And they have found some improvement through that mechanisms. And, as I said, it also helped build the infrastructure for the possibility of expanding their use of incentives by helping to identify measures sets and creating standardized data collection systems.

In an attempt to learn more about what's going on in the private sector, as I said before, we conducted quite a wide variety of interviews with purchasers and plans, providers, and quality experts on how incentives are used in the private sector.

I want to turn now to Sharon and she's going to go through some of the findings from our interviews.

MS. CHENG: On your next slide you see what we found to be the most prevalent types of incentives that were currently being used, were being implemented, and actually producing some

results among the folks that we spoke with in the private sector.

The most prevalent incentive that we found was public disclosure. In fact, almost every one of our interviewees used some kind of disclosure, maybe a magazine of hospital ratings or report on plan quality or a website with facility-specific information. That was either their incentive or sometimes it was the first phase in implementing another type of incentive.

Another common type of incentive was payment differential for providers. We saw a couple of different models for this. We saw bonus payments or a percentage of payment that went to a hospital or a group of physicians for meeting quality goals.

We spoke with only one purchaser who currently used cost differentials. We found that was a somewhat less prevalent type of incentive than the first two, though several others indicated that they planned to implement that kind of incentive soon.

Those who did not choose this type of incentive did tell us that they often felt it wasn't feasible, either because of a strong provider reaction that they had experienced or some enrollee resistance that they anticipated due to maybe the limitations of the measures or potential concerns about the impact on their enrollees.

Now I'd like to go through three examples of the types of incentives that we saw implemented and working out in the private sector. The first one is public disclosure. Our example for this one was PacifiCare. In California they release a quality index for each group of physicians to their enrollees.

One of the things we learned when we spoke with PacifiCare was that the progression was important. They began the implementation of this incentive by working with the physician groups, by discussing the scores and the quality measures with them. That allowed them to establish the credibility of the measures. They reached for measures that had already generally been used or developed, and allowed them to build acceptance of those measures.

It also allowed them to develop the data collection process. Here again, they tried to rely on existing sources of data. By working with the providers first, they provided feedback to those physician groups, which built their expectations for the scores, how the incentive was going to work. And also, they heard from the physicians that the feedback itself was seen as valuable by benchmarking and providing them with quality information. That was a value to the physicians in and of itself.

After they worked with the physician groups, they then made those scores available to their enrollees. They did this right before the open enrollment session, so it had the maximum impact. They provided information on clinical and patient satisfaction scores. Satisfaction would be generally for the group of physicians, but also the patients could rate their primary care physician. Were his or her instructions easily understood? Did they feel that that primary care physician listened carefully? Then they would give the group of physicians a start if they were in the top 10 percentile for their score on that measurement.

After making that information available to their enrollees, they saw some results pretty quickly. By making that available

right before open enrollment, within three months they found 30,000 new and returning enrollees had moved to higher quality groups of physicians. As a result, $18 million moved with those enrollees. They were in a capitated plan. And that moved to the higher quality providers.

Over the course of using this incentive, they've also found that scores have improved on 18 out of the 26 measures that they've used over the years.

For our second example, of payment differentials. One of the things that we heard when we spoke to private purchasers and plans as they were implementing a payment differential was, interestingly, setting aside the pool of money was straightforward. The hard part was determining who got those dollars and how they were going to be distributed.

For our example we talked with Blue Cross-Blue Shield of Michigan. They put about $40 million on the table to improve hospital quality.

Their program, again, had a progression. It began with a system of scoring the hospitals for reducing inpatient admissions for services that could be performed on an outpatient basis. After a few years of using this score, they found that most of the hospitals in their system were already meeting it. And they thought that it was time to introduce some new measures and some quality information into the scores that would be attached to this incentive.

They eventually have a mix so that it was 45 percent of new quality measures. Hospitals had to meet quality of care standards for such things as heart attack, pneumonia, complying with safe medication practices, or implementing a program of community health, of reaching out into the committee that that hospitals was operating in.

It's also interesting to hear that their scores and the information that they're using, they're also continuing to develop. They intend, in the future, to add a score for preventing surgical infections. And they're going to increase the mix of the score between the original measures and the new quality measures.

The distribution of those incentive dollars in this program remains a sensitive issue and it also has been changing as they've been using this incentive. In some years, hospitals attaining high scores were eligible for up to a 4 percent additional percentage payment on their Blue Cross-Blue Shield patients. In other years, this distribution method has differed and they'll continue to tinker with this as they work on the implementation of this incentive.

They, too, were able to share some results on this. All the measures of quality that they use in this incentive have improved. And the number of hospitals with the highest overall score has doubled between 2000 and 2002.

As our third example, we spoke with an employer that was using cost differentials. Here again, as we spoke with different people, we found a couple of different variations on a theme. Enrollee cost-sharing incentives that have been implemented or are planning to be implemented sometimes operate at a plan level,

so there would be different cost sharing on the premium for the enrollees, and sometimes at the provider level. So there would be different copays as an enrollee went to different providers.

The employer that we spoke with was General Motors and they've decided to allow their enrollees to choose health plans based on quality and cost. Their target was to improve the plans by motivating the enrollees to choose higher quality, low cost plans.

So their scores are a blend. 50 percent of the score is based on cost effectiveness, and 50 percent of the score are based on quality measures. Hereto, they used measures, they reached for measures that already existed; performance on HEDIS, accreditation status, and patient satisfaction. To motivate the enrollees to make a change, they offered lower premiums for the higher scoring benchmark plans.

There's a pretty wide range of premiums. You've got a premium range their on the screen, varying from $35 for a high-quality benchmark plan to $173 for a lower scoring plan.

As a result, a substantial number than enrollees did migrate to the higher quality plans and together GM and its enrollees in the health plan saved $5 million in one year.

This next slide are sort of some general observations that we've gathered from speaking to a variety of plans and purchasers using several different types of incentives. The first thing that we were encouraged to find is that in the private sector, the use of incentives is already somewhat widespread and, in fact, a Health Affairs article called it an explosion of report cards, which are usually attached to public disclosure incentives.

We found encouraging early results that these incentives appeared to work. Some plans and purchasers already had some results to share in improved quality and, in some cases, some savings.

Many of the incentive programs that are out there are still new, so hopefully they'll yield some more results soon. However, when we spoke with plans and purchasers in the private sector, many of them noted that their relatively small market share limited their ability to impel providers in their community to change.

We also heard that incentives for quality were used as a negotiating tool. As providers and plans sought the annual rate increases, the payers weren't willing to increase payments without some kind of accountability on the part of the providers. That's when quality incentives were put on the table.

We also heard frequently that there was a progression and that that was pretty important to having an effective incentive program. Involving the providers in the development of the measures and the scores was important, and giving feedback to those providers even before, perhaps, those scores were publicly disclosed, was useful and was valued by the providers themselves.

Frequently we heard that the toughest issue was finding the right measures and collecting and analyzing the data.

From our discussion some criteria emerged. What we've also done is we've given you a page summarizing the criteria that

we've developed and we handed that out just this morning.

The goals must be credible, broadly understood, and accepted. To be credible, we heard that they had to be evidence-based to the extent possible. They should be valid and reliable. They should reflect a broad spectrum of the services that beneficiaries receive from the provider being scored. And to be broadly understood and accepted, we've heard that the providers being compared needed to be familiar with and supportive of the measures sometimes before they were even disclosed.

Benchmarks should not be so high that only a few attempt to improve. Many or most providers should be able to improve upon the measures, otherwise we felt that care may be improved for only a few beneficiaries.

Interestingly, everyone we spoke with based their rewards on attaining a goal, rather than another option, which would be rewarding improvement toward a goal. Another interesting variant that we heard on this one was a program that had to maintain the gain adjustment. So that if a provider improved on some scores but slipped on others, they weren't eligible for the incentive in that round.

Incentives should not discourage providers from taking riskier or more complex patients. And to the extent that seeing healthier patients would lead to higher scores on the measured used, a mechanism should be included to mitigate those effects. We heard that using either appropriate case-mix adjustments or avoiding measures that needed to be risk adjusted were strategies that some in the private sector had used to avoid this problem.

And finally, we heard consistently that obtaining information must not pose an excessive burden on any of the parties involved. To the extent possible, measures should be based on data that is collected as a routine part of care delivery or for multiple purposes.

And now for this presentation, we're going to go back to Karen and she's going to explore how we would apply these incentives in Medicare.

MS. MILGATE: Because Medicare is already using a variety of non-financial incentives and also working to build the infrastructure that would be necessary to go beyond non-financial incentives, and because the most prevalent ones we found in the private sector were differentials either to providers or cost-sharing differentials for beneficiaries, we wanted to spend a little time exploring how those two might work in the Medicare program, both looking at unintended consequences as well as some more practical implementation issues.

Before we get to the specifics of that, though, there are also some broad issues with Medicare taking on the mantel of putting in place financial incentives. First of all, and probably the most easy to identify issue is its size. Medicare has the advantage of being a large purchaser so therefore it can really get the attention of providers. And also, it's easier for Medicare to get valid data because there are just so many more patients that would be Medicare patients. It's an easier way to get -- it's easier to get valid data.

There is a disadvantage of this size, though, as well. One

of the primary ones is up here on the slide. That is when you have a purchaser that's that large focusing on a certain set of measures, you're going to focus efforts on those measures. Which means you're not going to focus efforts, possibly, on other measures which might be important for some individual providers or for regions or for types of patients that somehow aren't included in your measures that, of course, have to be as good and valid as they can be. You might miss some important problems.

In addition, when you have such a large entity who is a purchaser but also considered a regulator in charge of defining measure sets, it could possibly slow the evolution of measures. It takes a long time for standards to change in the Medicare program and one can also think of how it might impact providers if for one year there are a certain set of measures and there may be a need to move on because some providers have met those goals, but others are way behind. How do you determine how fast to move ahead with the evolution of measures?

Specific to provider payment differentials, as Sharon noted, while setting aside the dollars to pay providers differentially was -- as you can anticipate, might have been somewhat difficult negotiation. In fact, the mechanism was fairly straightforward. However, the issue came about in terms of how to distribute the dollars, and then whether the measures were good enough to, in fact, pay dollars differently upon that basis.

So if the measures aren't good enough, provider differentials could disadvantage those with less resource or those who take riskier patients. For example, if you use outcomes measures such as mortality or complications and those are not appropriately case-mix adjusted, you could end up with providers trying to avoid those who are more complex or riskier patients.

On the other hand, if you used structural measures or some process measures that require resources in order to meet the quality goals, on the other hand you might then disadvantage those with less resources. For example, if you required hospitals to put into place computerized physician order entry -- some could clearly do it more easily than others.

Beneficiary cost differentials could create access problems and equity concerns. If the differentials actually worked and a large group of beneficiaries moved to the higher quality providers, it could place stress on the capacity of those high quality providers, and on the other hand threaten the viability of others who are lower quality providers, or lower quality at least on your scores that you've developed.

And in addition to that, Medicare really has a responsibility to ensure the availability of affordable providers. So for example, if in a particular area copays for a certain hospital, that might be the only hospital that's available to some folks, went up because they were designated as a lower quality hospital, that could disadvantage some beneficiaries.

There are also some implementation issues. It is very administratively complex to identify measure sets for all these various settings of care. It's also a challenge to collect and

analyze the data and design mechanisms for distributing either the lower cost sharing or the higher payment differentials.

Both these differentials would require new authority, new legislative authority to implement them. The provider differentials really, there's probably more precedent for those type of differential, as you all very well aware. for hospitals there is an adjustment for graduate medical education and for hospitals that take high levels of uncompensated care. For physicians there's an extra payment available for physicians who practice in high manpower shortage areas. So there's some precedent for adjusting payment on the basis of some policy goal. And in this case, it could be the goal of providing a high quality product to the Medicare beneficiary.

On the other hand, there is currently no authority to waive beneficiary deductibles and copays. In addition, as you all know, a program has grown up around the Medicare, which is the Medicare supplemental program, which might limit the effectiveness of actually varying copays to the individual provider.

One thing I wanted to note that we heard somewhat from the private sector is how beneficiaries might perceive cost-sharing differences. For example, if it was applied to a physician copay and a beneficiary decided to stay with the physician, if these scores were calculated annually, in fact, their copays might go up and down, which might be rather confusing to the beneficiary, why is this occurring?

On the other hand, if they moved to higher quality provider, they might have a higher quality provider one year, but maybe the provider doesn't maintain or stay up there. So then their copay goes up when they go over there, or they shift back to the physician.

Anyway, it just creates some potential confusion, particular at the individual provider level. We did hear that that was one reason why some plans didn't put those in place at the specific physician level, for example.

So what do we know? We know that Medicare is already using incentives and building the infrastructure to use them further. We've also identified that two most prevalent once in the private sector and discussed a little bit about how they used them and their implications for the Medicare program.

Our analysis has led us, at staff, to believe that in fact the costs of the possible unintended consequences and difficult implementation issues for beneficiary cost differentials, given that there are alternatives and a lot of work underway even before you would get to that to use incentives to improve quality, that we would suggest that the Commission focus its benefits, at least in this discussion, on financial differentials for providers. You all may want to discuss that further, but it seemed to us that the costs kind of outweighed the benefits in this case for that particular type of incentive for Medicare.

So the discussion that we've put in front of you here is whether Medicare should demonstrate financial differentials for providers.? And if so, how Medicare should use that demonstration authority? And if the Commission wanted to

recommend that CMS use the criteria that emerged from what we saw in the private sector to help focus their demonstration authorities, we've suggested a recommendation that might do that.

In addition, we'd like to come back to you in April with several setting-specific or condition-specific suggestions where incentives might be most effective.

So the recommendations would be, first, that the Secretary should conduct demonstrations on provider payment differentials to improve the quality of care. And then, as I said, if the Commission wanted to be helpful in focusing CMS in its effort, to suggest that CMS use the criteria which emerged from the private sector analysis to determine which settings of care and types of incentives may be most appropriate for Medicare.

So this concludes the formal presentation. We'd appreciate your comments, both on the recommendations but also you have a draft chapter in front of you. So we'd like to also hear comments on whether it's the right focus, if we missed anything important.

MR. HACKBARTH: I'd, in particular, like some discussion of the issue of provider incentives versus the beneficiary. My own view, and I talked to some of the staff about this, was that given the prevalence of supplemental coverage in Medicare, it's very difficult to translate an incentive down to the beneficiary level. And so if we're trying to provide some of assistance on where to focus efforts, it does seemed to me that that was naturally a lower priority. But if others disagree, I'd like to hear opinions on that.

Why don't we just go around the table this way. Ralph?

MR. MULLER: I'm pleased to see this chapter because I think it's very well a compilation of the thinking in this area.

I agree with Glenn that the incentives should look at the provider side first. And I also would urge us that we look at incentives that are fairly powerful. When you think about the traditional incentives for quality, they are right now, whether it's a doctor, a hospital, a nursing home, or a home health agency or whatever, to be perceived as a quality provider in a setting where there is choice, and therefore get activity. It does work at times, that people do come to those places that are seen as better.

Obviously, in settings where there is only one of it, it becomes more difficult to have that kind of choice. And there's still an awful lot of evidence that people tend to choose their providers based on location rather than any other measure of quality.

But the obvious incentive, when one gets more patients, whether one is a doctor, a hospital, a nursing home, is a very powerful incentive and the traditional way that has worked over the years.

So as we think about this going forward, one of the criteria I would add to the list is that these be reasonably powerful because, as you point out very well in your chapter, there are a lot of counter measures that allow quality not to be rewarded. So you have to have incentive towards quality that at least the margin outweigh those for lesser quality or lack of quality or

not paying attention to quality or just having activity.

I think the experience I've seen in some of these efforts over the years is by and large if you have a kind of 1 or 2 percent incentive towards quality, and not necessarily 98 percent in the other direction, but let's say a powerful incentive to not focus as much on it, it just doesn't have as much of an effect on the margin.

Therefore, in the work that you're doing in terms of writing up some of the -- whether it's the PacifiCare one or the Blue Cross ones, I think it would be helpful in our analysis to get some sense of financial impact. So for example, you noted I think that 30,000 enrollees switched coverage. What is that on a percentage basis? What's the kind of one-year or three-year effect of them switching activity? Is that seen by PacifiCare as powerful in the longer-term?

If Blue Cross of Michigan is providing incentives to providers again, to some rough metric of proportionality, just how big an incentive is this is compared to other incentives that they have? Certainly, as they're gauging and guiding their behavior, they're making judgments all the time at the margins to where to put their efforts.

So again, I think, a very well done chapter and a very appropriate effort, but again I think it's important that we get a sense of the depth and power of these incentives vis-a-vis other ones. Because there's always like 10 things going on at once, and it's important, if we're going to have the incentive towards quality, I think one of the reasons that all of the reports keep coming out, and you don't see much activity toward it is -- there's a lot of talk here, but not enough money and other kind of support to back it up and cause people to start acting in a different way.

MR. DeBUSK: I'm going to take a little different stab at this because financial incentives for the provider, I think, is a must in the system. But looking at this, there's two pieces. There's the process, PC-squared, the process and the production. Folks, we're over on the production side. We're on the tail end of this thing. You don't improve anything unless you get back into the process.

To illustrate this, I think in October Dr. Berwick, Dr. Jones, Opportunities to Improve Health Care, Crossing the Quality Chasm, Aims for Improvement, they very well illustrated the value of protocols and that you can get better outcomes and better performances with protocols.

Now let's go back and look at our system. We're in a system, a coding system. We've been prospective payment for the hospital. We've got a system for the post-acute areas now, we've implemented the last one.

Within those diagnosis codes, those ICD-9 codes, lies a descriptor. And ultimately we go from that diagnosis code to a payment code. For devices, for treatments, the roll-ups, the 3M systems that roll all this up.

If you go back and you look at the protocols, application, and you tie it into the system, and you start measuring how well a provider is using protocols and pay on the participation on the

front end of how well you do at this, at implementing the process, engaging the process and managing the process, the quality is going to be there.

But what we're doing is we're doing it in reverse. We're using the stick, in most instances.

I'll promise you one thing. It will not work. Been there, done that in industry. But there is a clear cut opportunity and it lies within the fact that we've got the coding system put together. It's not going to go away. It can't go away. But how do you reward a physician or a hospital? Are we talking about cookbook medicine? Absolutely. Absolutely. The outcomes, what the results of this has very well been demonstrated.

Now, I'd like to propose a bullet point to go on page 31. I'd like to propose this bullet point. Protocols should be implemented in a manner that would allow financial incentives for the doctor. hospital, and other providers based on their participation. The data for payment needs to be taken from the diagnosis and payment code system.

The data collection should be seamless. It should be a part of the coding system. Unless you get it to where it could be managed and it can be collected on a seamless basis -- looked what happened up there with Hoyer and the guys at CMS. We come along with all these coding systems to do an OASIS. And to do an OASIS we only need about 22 of the 51 categories to make payment. But we've got all these other data collection pieces in here. As a result, it's real burdensome so they don't do it, a lot of it, or else they just whip through it.

But you back to the nursing home industry, all that, a lot of that data collection, it is the quality information. And it just doesn't get done or it doesn't get done properly.

So the opportunity, I guess to use Demming's teachings of PC-square, it's very real. Is there a place to begin? Yes. And it's so much easier than what we're doing here. We're going to beat this thing to death, until we get out of this box that we're in and re-look at this and say is there an easier way to do it.

MR. SMITH: Sharon, Karen, I thought this was a terrific contribution to this discussion. But I mostly have questions. Let me begin with one that is connected to Glenn's observation at the beginning.

Do we have any experience -- and I was wondering about GM in particular -- with somebody in the Medicare supplemental market trying to use incentives? And what do we know about the effect on beneficiaries? Was GM's effort simply aimed at current employees? Or did it go to their retires, as well?

MS. MILGATE: I believe it was just their current employees. I think we even asked that question.

We are not aware of anyone using it in the supplemental market. I mean, you can think of ways that maybe it could be done through the premiums for supplemental. But I think Glenn's point on how it might impact using it for copays for providers is clearly true.

MR. SMITH: That seems right and I just wondered if, given GM's very large --

MS. MILGATE: We haven't but it's a question we could ask --

particularly go back to them and see if they thought about it and decided not for some reason.

MR. SMITH: Even just getting their thinking would be helpful.

I wonder, is the assumption. and the Michigan Blue Cross example is a good one. But is the assumption that the pot will be paid for out of savings? And does that take us to a way of getting to size Ralph's questions about the power of the potential pot? Where did the $40 million come from? What was the assumption?

MS. MILGATE: That's a very good question and we didn't specifically ask Blue Cross that, but we did ask some others that. And I won't name names on this one.

But what they said, particularly about the beneficiary cost-sharing, and the payment differentials for providers is a little bit different case. But the beneficiary cost-sharing, the cases we saw on that were based on both cost and quality information. I don't remember one that wasn't.

So the point there was in some of the earlier stages, in fact, it was only cost information. And in fact, it was a progression to move to put in quality information there at the same time. And the entity that we talked to specifically about how those added up, because clearly the purchaser or plan was going to pay more for the enrollees who went to the higher quality, low cost folks, because they were going to pay more of their share. And they said yes, there was a calculation there in what they would save because those were lower cost in addition to higher quality, as to what they would spend for encouraging enrollees to go there.

Now in terms of the payment differentials for providers, several folks told us it was very important that that be at least perceived as added dollars and not just for perception purposes.

MR. SMITH: Added dollars to the provider but not added dollars in the system.

MS. MILGATE: Added dollars to the provider -- well, to the system because we're talking about a context of a negotiation. So it's kind of hard to ferret out, is this really just new money that they set aside, or this money they otherwise would have gotten in a payment increase? That's a hard question to ask an insurer to tell you about.

DR. MILLER: I just want to ask for a second, when were talking about this, at least at one point in time, I thought we were saying that they pretty much negotiate, the private employers negotiate what their premiums are and what they were going to ultimately pay for whatever set of lives. And then, within that, is how the differentials were --

MS. MILGATE: I would say that would be generally the mechanism, yes. So there would be some redistributive effects there.

MR. SMITH: Two last questions. I don't want to take too much time but Sharon, you talked about the importance of criteria that don't invite adverse selection. Have we had enough experience now with these plans to have some indication of what happens? Or are the perverse incentives that we are worried

about, do they persist or do we have evidence to suggest that there are tools to avoid them?

MS. MILGATE: I would say it's mixed. The story is kind of mixed. The difficulty about that question is that while that was a big concern for those we talked to, what concerned us most is that the way we felt like they -- I don't want to use the term got away -- but the way that we felt like they were able to use these measures and not cause as many problems as might occur in the Medicare program, is because they did have fairly low market shares.

So the providers were not as sensitive to it. They also said it was one reason they stayed away from some outcome measures. It was also the reason that they sometimes did not want to go to do cost differentials for their enrollees, because they weren't sure.

And the other mechanism we saw to try to mitigate the impact of some kind of encouraging providers to take riskier patients, of trying not to do that, was to take -- not to categorize say the whole provider as a high-quality or low-quality provider, but perhaps have a matrix of measures so they could be good on some and not so good on others. So that then, you had the whole panoply of measures, some of which didn't even need to be risk adjusted. That you had a real mix, and that people could then choose on those basis.

But I would say that we don't -- no one would say that we have great case-mix adjustment in probably any setting. There are sort of a spectrum of how good you can get.

MR. HACKBARTH: I would think that the risk would be principally with regard to outcome measures. To the extent that you're using more measures of clinical process, the risk would be diminished. Although there could be issues about patient compliance and some groups of patients being more able to comply with the medical instructions, whatever they might be.

MS. MILGATE: Yes.

MR. HACKBARTH: But wouldn't it be principally in the outcome area that the adverse selection, the risk adjustment problems, would be greatest?

MS. MILGATE: Yes. And the big controversy in the New York Times...

MR. SMITH: One last question. Sharon, you said that universally the folks that you talked to on the private side had rejected improvement criteria in favor of benchmark and either you meet it or you don't. Could you talk a little bit about their thinking on that? Sort of what you learned from why they came to that conclusion?

MS. CHENG: Part of my impression was that it was the most straightforward way when it came to scoring. It was easier to set a goal and then meet it or not meet it, than to try to score whether somebody moving from a 35 percent to a 45 percent was better or worse than moving from 80 to 85. I think it was a reaction on their part to try to take a little of the complexity out of the system.

There was also a sense that it was a little bit more palatable. That attaining the goal was somehow a little bit more

worthy of rewarding than someone who was perceived, according to the score, to be on the lower end of the score and moving up but remaining on the lower end of the score. So I think there was a little bit of that.

I don't know that we heard too much struggling back and forth, as to why they didn't try some kind of mix or why others didn't.

MR. SMITH: Thanks.

DR. WOLTER: One of the things that interests me on this topic has to do with the organization of health care and then the infrastructure that it would take to really address these quality issues, and so a few specific points.

On number four on your implementing incentives, I think that there is an issue around information that isn't just measurement, but it's implementation. As the information systems are now maturing, clinical information systems that allow order sets and clinical pathways to be standardized, I think we're going to see a lot of bang for the buck there, in terms of how we standardize care and end up with better outcomes.

So it seems to me an important contribution we could make is to be recommending that there be some investment made possible in technology and in information systems, that not only allow better measurement but are part of how you implement improvements.

I think, in some ways, that's almost counter to what number four currently says because I don't think concurrent financial systems are going to be the place where we make these improvements. So that would be one thing.

Another thing, aside from technology, as I mentioned, is just the organization of health care. Much of what we're talking about doing does require collaboration. We can talk about incentives related to the current financial silos, for example in the Medicare system, and that's fine, we can probably make some incremental improvements. But ultimately, if we don't provide a set of payments that incent physicians, hospitals, and others to work together, I don't think we can really make a lot of progress on this.

In fact, the current payment mechanisms really don't provide any incentive or very little incentive for the various players to work together addressing quality issues.

Having said that, what is the answer? We're not going to solve that between now and June. But I think that something in the payment system needs to start happening that brings people to the table to work together. And I don't think it's an accident that the demonstration projects revolve around group practices or about the health plan level. We may want to explore that a little bit further in terms of our own recommendations.

For example, some very specific things. If there were payment for nurse clinicians and others who coordinate the care of those with chronic disease, that might be really a good thing because I think those are the activities that will really make a difference.

And then also Don Berwick mentioned this when he was here, but the whole issue of payment within a given time frame, and how does that work, and how do we set up incentives in a twelve-month

period versus a three or four or five-year period, that's another tough issue which we probably won't have a specific recommendation on, but we might want to make some comments about the fact that an investment, however we set it up now, it may take three or four or five or even longer years to show up. So payment outside of the current time silos.

And as I said, also, I think payment outside of a budget neutrality approach may be an important issue as well, because some up front investment may be required in order for us to see savings down the road.

This is a complex topic. I'm sure we could all go on and on, but those are a few thoughts.

MR. HACKBARTH: The issue of the role that better information systems could play, I think, is an important one, and certainly one that's gotten a lot of attention recently. Some of the recent IOM reports, for example, have made at least broad recommendations that the government ought to be doing more beyond the VA system in supporting the development and implementation of improved systems.

It's a very complicated subject, in terms of what, in fact, Medicare could do constructively in that area. But because it's gotten so much attention, I'd like to see us at least not answer the question, but have some discussion of it. I asked Mark if he could help us, for the April meeting, just sort of lay out some of the issues there and we can make a judgment about what, if anything, to include in our June report.

Alice?

MS. ROSENBLATT: I, too, thought the chapter was excellent, and just a couple of points.

First of all, to the specific question Glenn raised. I would not rule out beneficiary cost-sharing. I think, particularly with the PPO plans now, we're seeing instances in the marketplace of beneficiaries dealing with different cost-sharing. So I would keep that on the list. Maybe provider should be the first priority, but I wouldn't rule it out. And I noticed there was a change in the way the recommendation was worded in this material versus what was up there. I would keep it in.

To answer David's question, I think, from what I know of the marketplace, in general you might think of it is a redistribution, I would think. It would like an across the board increase to all physicians versus less of an across the board increase in some targeted money going for specific things.

To pick up on the systems thing, we always talk about data and we always bemoan the fact that we're using data that's two or three years old. I think any quality system, part of any quality system needs to include timely feedback to the providers. If you don't have that, it doesn't work. And two-year-old data, I would not consider timely feedback.

So I think, in our list of criteria, we really need to hit on that timely feedback issue more.

Two other points. One is, you mentioned disease management capitation. I have a lot of concern about that. We've done a lot of work on disease management at Wellpoint and the numbers

that I've seen for the typical kinds of diseases like asthma, diabetes, congestive heart failure, the standard deviation is enormous. If we're going to talk about that, we might want to put out a warning about how there is wide variation in that kind of cost and capitated system is difficult.

The other warning that I would put out is if you're going to put savings numbers like on the General Motors things, the other thing that I've seen in the industry is these savings are being calculated in bizarre ways. I mean, the most typical way of measuring savings is to say well, in the absence of doing anything, our trend would be 10 percent. But if we actually achieve a trend of 8 percent, we've saved 2 percent.

So be very careful before you quote a savings number and understand how it's being calculated.

MR. HACKBARTH: On disease management, your concern is about the payment method of capitation, as opposed to --

MS. ROSENBLATT: I'm concerned about what's in the capitation and is this sort of going to be the next thing that blows up, that companies are going to start doing, some of these disease management companies are going to start going on the risk, and the whole thing is going to blow up.

MR. DURENBERGER: Mr. Chairman, thank you. I'm just so happy to be here for this discussion I don't want to critique it, because it's kind of one of the things I came to MedPAC for. This and the variation discussion we had yesterday is sort of like getting at the heart of it.

So anything I say, I hope is a compliment to the excellent work you've already done.

On PowerPoint number three, I think it would help if we reflect that Medicare has a tradition of trying to deal with quality, even though it's basically an administered pricing system, and so forth, and go back to PSRO and PRO and some of that sort of thing. And in our own way, as a program, the QIO is sort of like the latest evolution.

But I think there's been a tradition here, at least some kind of a commitment in the program, to respect quality.

On PowerPoint number five, particularly as it relates to the physicians, and you may well be aware of this, since about 1993 or 1994, Minnesota Health Plan has been putting a lot of money into something that nobody really knows much about called the Institute for Clinical Systems and Information. Practically every doc in the state of Minnesota now has had an opportunity over the last eight to nine years to go through basically a quality education and training program.

So in one of those inside out, bottom-up, nobody knows about it, nobody set criteria, there are in place -- at least in one piece of geography in this country -- not something that was opposed by the health plans or set up by the health plans, but paid for and run by the docs. And that's a good example, I think, of how to try to build a culture of quality rather than centers of excellence in a community.

To the recommendation, which was the chairman's question, I just think it's critical that the first recommendation that we make in this area not be as specific as the one that's been put

before us. I like the Institute of Medicine's recommendation, which is that we ought to have, in our system and in our organization, we ought to have a culture of quality, not centers of excellence. That's stuck with me. That's on all my PowerPoints when I teach now. We don't have a culture of quality.

And if anything, it seems that the goal of the Medicare program ought to be to use its role and exercise some responsibility for helping to create a cultural of quality.

I don't personally believe that the provider-paid differential is the way to start. It's already been spoken to. It's sort of this top-down administered, you know the latest whatever it is, and I'm uncomfortable with that, at least at this stage.

For reasons others have stated, I have some difficulty with the beneficiary differentials at this stage, as well. And I would suggest that we, having set our goal at a culture of quality, that we think about provider incentives. I think, listening to the comments of my colleagues before me, while this isn't the specific program, it is a way in which people with different ideas, I think, can come to some conclusions about what's the most appropriate incentives in a third-party payment system, whether it's private payers or public payers, that will incent the physician, the hospital, the whatever it is.

So that if we explore that issue just a little bit more, and I'm sure it gets complicated and the economists can deal with it a lot better than I, but the issue for me becomes what could we do in the area of provider incentives?

I agree with Pete about systemic failure, with Nick about the organizational challenge, and so forth. But I think if we look at this issue of provider incentives and we encourage the administration to be looking at it as well, they've got something to tie some of their things together on.

We have one to recommend in a state-wide demonstration in Minnesota in which you simply allow the community of doctors and health plans to work together to design the measures and the various standards that they're willing to use in order to demonstrate to Medicare that they can do better care for less money. And I won't get into the details of it, but it's a bottom-up rather than a top-down theory of providing incentives to the providers to do some of these kind of things.

The last thing I would say with regard to HHS, in particular. Your report reflects the importance of measures, standards. It doesn't mention the privacy issue, the security issue, the confidentiality issues, and then the investment.

In this institute that I run, we now have 22 health organizations from the state of Minnesota plus Fargo, North Dakota; Sioux Falls, South Dakota; Eau Claire, Superior, LaCrosse, Wisconsin. A lot of those are in the tradition that Nick talked about. They've already built themselves up either to paperless systems -- they are on the verge of trying to do quality based or performance-based. They're estopped not by money so much as they are by the lack of uniform measures, the lack of standards by which to use the data. And the problem that

the states are posing with privacy regulations and things like that.

So before Tommy Thompson rushes off to invest a lot of money in technology, I think he ought to be focusing -- as an administration, we ought to be focusing on how do we get consensus on the measures, the data, and some of those sort of things. Because I believe that there are organizations now across this country that are poised to move in some appropriate direction if some of those issues could be taken care of.

MR. HACKBARTH: Dave, can I just try to get a better understanding of your first point?

I think back to the discussion we had with Don Berwick and Brent James. And the takeaway that I had from that was that first and foremost you need what you characterized as the culture of quality. That's a necessary condition for success.

But what I heard Don and Brent say was that even where you have that culture of quality, it isn't sufficient. It's necessary but not sufficient. And Brent gave a number of examples where they were committed to quality but they were having problems because there are programmatic costs that you incur to set up systems. And the savings, which he thought were real, often don't accrue to the providers who make the investment.

So I heard from him a quite explicit call to marry some financial rewards with the culture if you're going to have success.

MR. DURENBERGER: And he also said a lot of other things about use the disease management program at the Health Partners, which has been in existence for 10 or 11 years now, as one of the business plan examples, in which it's so hard to prove that you're making money for a variety of reasons, including the fact that because your beneficiaries can move and out every year, they don't even know they're getting the benefit, they're reaping the benefit of your investment in long-term payoff.

So there's a whole series, I believe, of changes that need to take place in the current system, starting with not rewarding poor quality and issues like that, which is more complicated, that fall under rubric -- all I'm saying is don't start with one specific recommendation. Let's start paying people for distinguishing this provider from that one.

If you looked at some of the Health Affairs, or wherever it was, article on that thing out in California that Jamie Robinson was part of, the hospital tiering. It's just another effort to say somebody knows how to select this hospital versus that one. I don't think we're ready -- my instinct is I don't think we're ready for that. But I think the hospital and the docs are ready to make some moves, if in fact we could help them identify the kind of base that they need.

And then, when you get to the health plans and so forth, that's where you start thinking about where are the changes that need to take place to provide incentives for the beneficiaries.

So I don't want my recommendations misinterpreted here. I'm so anxious to see us do this in the June report, but I don't want to get too specific about a solution because I'd like to see a

wide variety of solutions cutting across various recommendations we've got.

DR. REISCHAUER: Karen and Sharon, I think you really did a tremendous job and presented it very well.

I guess I disagree with Alice, and to a certain extent, Dave, in the sense that I think we should be very explicit in our recommendation that the Secretary should focus on financial incentives for providers. I think your chapter actually laid out a very strong case why, in the fee-for-service part of Medicare anyway, incentives for beneficiaries are unlikely to be effective, are going to be difficult to implement, and are going to be politically nonviable. And rather that having HHS reinvent what you've already nicely summarized, I think we should say this really isn't the road to go down or to focus your effort on.

However, also to point out that in the non-fee-for-service component of Medicare, be that Medicare+Choice or enhanced Medicare PPO, there's a very effective way of providing the incentive, and that is to vary the Part B premium for high-quality versus low quality. So should the structure change, or the parts of the structure that are appropriate for this, there is a mechanism that's fairly simple and we could move forward on that front.

I also think you should be a little more explicit about advantages and disadvantages of absolute thresholds versus relative distributions when we come to measuring quality. I think it was PacifiCare or somebody said we reward the top 10 percent with extra payments. That strikes me as not an approach to go down, simply because what you want to do is reward meaningful differentials in quality and the distribution could be very, very compact and the difference between the 10th percentile and the 90th percentile could be, for all practical purposes, meaningless. And we don't want to go down that road.

Finally, I think, although it is uncomfortable to do, that we should at least have some discussion of the political geography of this issue. The decisionmakers for this program are geographically based. We know there are huge differences in practice patterns across the geography of this country. There are probably huge differentials in average quality across the jurisdictions of America. That's strikes me as the major hurdle here to moving forward because. as you say, this does require legislation.

To the extent that you set out a threshold that is national, it is conceivable that very few providers in certain congressional districts, states, will meet that threshold. If that is the case, you're not going to see that legislation move one inch forward.

I think it's worth discussing the possibility of combining extra payments for high-quality providers with some temporary resources for those areas that are low in quality to improve quality. That it's going to have to be a mix of these two over the original -- over the transition period or else the way to do it is to start with very low thresholds for quality and legislatively explicit increase in those over a decade up to a level that you want.

But then what you're doing is really prolonging the period because you'd be distributing very little money to anybody with high quality or measured quality above this low threshold because so many people would be eligible.

But in theory, what we want to get to us a system in which everybody is rewarded for quality. I mean, that the quality improves throughout the country and in effect, the payment differentials provide, in effect, little incentive.

DR. NEWHOUSE: First, I think this is really exciting and a tremendous potential opportunity. In terms of the chapter and the draft recommendations, I thought it was good as far as it went, but it didn't go far enough. So I actually disagree with David, I think. I would like to see somewhat more specificity along a couple of dimensions.

First, I tend to agree with Glenn and Bob on the provider-side incentives although demonstrations don't have to be mutually exclusive. But I think that's the place to start.

Where I'd like somewhat more specificity is, first of all, the process that would be engaged in for determining what exactly is going to be demonstrated. Would CMS appoint some kind of outside committee? The IOM? Do they ask, as the Department of Defense would if they were going to have an airplane, for various design groups to design prototypes and there would be a form of competition?

I don't know the answers to these questions, but it would be nice if we could think about something to say about how we get from here to there.

Then, on the process and outcome side, I think we have to recognize that we're dealing with a population that has a lot of comorbidities which complicates both process and outcomes, frequently brings multiple providers into play. Then there's the question of who gets rewarded or penalized? For what? There can be, as we know, coordination problems across the multiple providers. What's the mechanism for getting at the coordination problems?

This would presumably all be addressed in the design phase of what are we going to exactly demonstrate? But then we are back to what is the process for determining this?

Ditto in the strengths of the incentives. Are we talking about 5 percent of the payments? 30 percent of the payments or what?

Then I think there's a question that we should, I think, say something about at some point that Nick touched on, which is the time it's going to take to actually do this. There needs to be some kind of design phase time. There probably should be some kind of pilot for how feasible this is, or working out the bugs in this.

Then there's the question of how long are you going to wait to get cost estimates? People have talked about downstream effects. There are some interim learning that could happen. But I think we need to get across that we're talking about a long-term project here and that we're not going to likely have useful information quickly.

So that brings me to a second point, which is that the CMS

track record on actually learning things from demonstrations is not great, for a lot of reasons that are not necessarily having to do with CMS. But I think here we ought to be fairly specific about saying to the extent practical we would like a randomized design, so that we actually learn something about what the effects are here.

Then I think this is a really hard question to figure out what exactly should be done here. I'd like to encourage us to put this on our retreat agenda for some discussion about where we go, and see where we get.

Then one final small point about Bob's comments about PPO and M+C. My question there is what did you have in mind? In effect, these entities or certainly the M+C plans are going to determine their networks which, to the degree they do that on the basis of any quality measure, it implicitly puts in a financial incentive on the consumer side. So I'm not sure what exactly we were advocating, if anything, or you were thinking of on the PPO and M+C side, but you may...

DR. REISCHAUER: I was thinking of steering beneficiaries towards those plans that had higher measured quality, by varying the Part B premium for those who join quality care golden versus resources average care brown.

DR. NEWHOUSE: In some kind of market-specific fashion? Plan A could be doing great in San Diego and lousy in Los Angeles.

DR. ROWE: Can I ask a question? I'm sorry I came in late, and I don't want to interrupt but I'm trying to understand this.

If you want to steer beneficiaries toward plans with higher quality, you would presumably do that by charging them a lower premium. That would steer them into it.

DR. REISCHAUER: That's what I said.

DR. ROWE: And then you're paying the providers more because they demonstrate higher quality, so that the premiums are lower and the payments are higher. So how do you --

DR. REISCHAUER: No, this was in a discussion of incentives for beneficiaries, as opposed to incentives for providers. So all I'm trying to do is lower the cost of participating in high-quality plans from the beneficiaries' perspective. I didn't say anything about the other side.

MR. HACKBARTH: The provider payment would be based on the plan's mechanisms. That would be a plan decision on how to pay the providers. He's just thinking about the beneficiaries.

DR. REISCHAUER: You could do both. You could lower the Part B premium and raise the capitated payment for the plan.

DR. ROWE: Maybe in your world you could.

DR. REISCHAUER: I thought you'd like this.

MR. HACKBARTH: Joe, what I understand you're saying is that your mental image of what needs to be done in terms of demonstrations is much more like the Rand health insurance experiment as opposed to the demonstrations that we more typically see?

DR. NEWHOUSE: That was the burden of the randomized design comments, but I think while it's fine for us to say we'd like demonstrations on quality of care, if we're actually going to get

something out of these to design is a tremendous task. Anything we can contribute alone those lines, at a minimum saying something about what the process ought to be, who designs this or what groups are involved, and how much time do we think is necessary and so forth, those are all very important decisions or this could amount to nothing at the end of the day.

DR. WAKEFIELD: Nice work. Just a couple of comments.

First of all, in the early part of the chapter you discuss disincentives in addition to incentives. I'm not sure that you can go down the road of disincentives much farther than you already have. Perhaps disincentives and incentives are two sides of the same coin. I don't know.

But it did strike me that if there were options, if we knew clearly what some disincentives were and there were options for removing those -- it might be regulatory burden for certain regulations, I don't know. But maybe there are two or three out there that can be identified that we could also say, and here's a place to start, not just to move and create new incentives which is critically important but also is there anything that could be rolled back or adjusted that right now is serving as a disincentive?

I didn't give it much more thought than that, other than to say you did a nice job of raising it early on, sort of the perversities in some of the financial disincentives.

I was wondering is there anything more that could be said about that? I'll give it some thought, too, but if there is more, that might be worth expanding a little bit of a discussion there.

The other comment I wanted to make or another comment that I wanted to make is that the option of at least considering by way of example in the text incentives to improve and further push the development of infrastructure, information technology, information systems. I know other people have commented on different ways thus far, and clearly some institutions are moving rapidly on that front, others are not moving as rapidly for financial probably even cultural reasons, in terms of people feeling comfortable with using those systems and wanting to deploy them and so on.

But I'd say, by way of example, one of the core patient safety standards from Leapfrog was, of course, their computerized physician order entry system. What did it accomplish? Of course, it accomplishes improvements in medication, in decreasing medication errors.

But it also, in the process, contributes to improvement in the information structure, the IT of those hospitals where it's deployed. And that also, beyond medication error directly, enhances the ability of those facilities to measure and to engage quality improvement more rapidly than they probably would be able to if they were still using paper and pencil, or whatever other parts of the system they had.

So I think we're seeing sort of fits and starts in terms of deploying clinical IT in really complex care systems, and anything we can do to help try and extend those activities is important.

I would say this is not all rural and it's not all urban. Just by way of example, and I know I used this once before but I'm going to again just to make the point. In a teaching hospital within a very short distance of us right here, I've said it before, when I was working on the To Err is Human Report with my colleagues at the IOM, at the very same time, my Medicare beneficiary mother underwent to laterality procedures at two different institutions within this geographic area. In one, a surgery on the wrong wrist. On another, a steroid injection in a hip under fluoro on the wrong hip.

So you think our tertiary care teaching facilities have got everything up to snuff. In querying that tertiary care teaching facility on the latter point, the excellent physician surgeon who did that injection, about why did this happen? Well, the answer, from his perspective, was I didn't have the chart here. The chart was still in the clinic. And the clinic is just feet away from this outpatient unit.

So the point is to say that we've got some information systems built into some parts of really wonderful structures, but they're not necessarily threaded through. This wasn't an OR suite. It was an outpatient ambulatory care suite. So they had fine corrections and preventive measures that had been deployed in their OR, but they hadn't in their outpatient ambulatory care side.

So I'm saying I don't think we're as consistent with using IT as we could be, and I don't think it's just a rural/urban problem. I think anything we can do to improve quality and use this as a driver, as difficult as that is -- because I will tell you, in this case, Medicare paid twice for both procedures. And she paid twice, having to go through those procedures, yada, yada, yada.

So that's that point.

One might also think -- well, this is probably heresy. But as we even think about GME subsidies, perhaps one thing we could think about over time is whether or not we'd want to help pay hospitals not just to train physicians in residency training, but also try and encourage those environments to move away -- that they're training, that those residents are operating in, from moving away from paper-based to broader IT-based on institutions that have really got very strong safety reporting and improvement systems embedded within them. So we might think about casting that a little bit more in that direction, for another day's discussion. But it just makes my point.

The last point I want to make is the House just passed legislation authorizing the establishment of patient safety organizations that can collect and report information confidentially on errors for the purposes of systems improvement. One might say that that is the sort of thing, I think, that if it's enacted, it would be great to link that with some financial incentives for hospitals and physicians and others to participate. So maybe they'd get a break from something else, from some other regulatory burden, if they step up to the plate and they participate in the creation of that new reporting system, if in fact it would make it all the way through.

But it's just the point, are there breaks that we can provide to those providers that engage in these early efforts, both financially, some financial incentives, and also some regulatory relief wherever we might be able to find that in the system to try and encourage these quality improvement efforts.

Last point, I actually really certainly support the first recommendation. I'd be happy if we could add to it, but I think it's a fine place to start.

I'm not so sure about the second recommendation. I think the criteria that you've listed are good. Whether or not they are embedded in a recommendation or they're discussed in text, either place. I don't feel strongly. I think they're find to have one place or the other.

The last point I was going to make is we also might say, somewhere in the text, unless they automatically do it -- you'll know the answer to this question -- but you might also try and have CMS engage with their colleagues at the Agency for Health Care Research and Quality for some of their research to get at your point earlier about how do you structure these demos in a meaningful way. Let's bring the folks who know a lot about different pieces of this together. We might encourage that, at least in the text.

And I'd also say on the rural side, the Federal Office of Rural Health Policy has really been moving a lot on quality on the rural side. And that would be another player inside HHS to bring to the table to really get the very best we can out of this effort.

MS. DePARLE: I agree strongly with everything Bob Reischauer said, so I want to just echo him but highlight a couple of points.

One, I think that it is important for us to be as explicit and specific as possible with our recommendations. So I guess I slightly disagree with what Senator Durenberger said there.

I think CMS, I think the Administrator, and I think the entire agency is very committed to this. But they are very limited in their resources to do demonstrations. As much as we'd like to talk about how the whole thing is designed, that's an incredible burden. And also they have to work very closely with the Congress and we start talking about doing randomized in someone's congressional district, I can sure you that it's not -- the Rand Project might have an easier time of that than CMS would.

So I think we need to be as specific as possible.

And therefore, while I'm open to looking at beneficiary differentials, and I would suggest that the centers of excellence demonstrations that were done actually did do some of that, and I believe with some success, although as Glenn or someone said -- oh, I guess Joe, you said, the learning curve in learning from demonstrations is a difficult one, not all because CMS doesn't want to learn, but because sometimes what they learned is not what everyone wants them to have seen.

But anyway, I think that it's important to be as specific as possible and to focus probably on the provider side of this, because I think that's -- there's low-hanging fruit there. It's

easiest to go there, first.

I'm glad to hear, Glenn, that you and Mark discussed doing a little more work on the clinical information systems front, because I think that's a really important area. I think even in this room we've heard different things about where are we really with that.

I was heartened by what Senator Durenberger said about the progress he's seeing in his area of the country. But I have no idea what we really stand. How many hospitals are moving forward? How many aren't? What do they have? What do they not have?

I don't know, Mark, if it's possible, this might be something you have to contract out for, but to come up with some type of typology that would give us some information about this. And even, I think Bob is right. We probably need to look at it from a regional basis as well, just see if we can make any determinations about where we are there because we have to be realistic. That's what we're going to have to deal with if we want to move forward here and see what are the barriers?

We've heard that cost is a barrier. Medicare pays capital costs now. How much of this would Medicare already pay for? Are there other changes we could make?

So I'd like to see us do some more work there.

DR. NELSON: I certainly support going ahead and I support the recommendations. But I think more attention needs to be given to the implementation barriers, especially with respect to ambulatory care. On page 26 we say credible measures of physician quality are also available often through data collected by CMS claims data. But I submit that claims data are poorly suited to identifying individual performance. You may know that a Pap smear was done. You don't know whether to give credit to the primary care physician who recommended it or the OB who did it, or a nurse clinician who did it.

Claims data are not suited for identifying individual compliance with best practice protocols, as Pete pointed out. Especially without drug data. You just can't do it.

I was part of IOM studies called Effectiveness Research in 1990 and we tested the thesis that this enormous amount of claims data for Medicare could be used to draw quality inferences. Very few. Usually we ended up recommending the PROs go look at the charts.

Finally, for fee-for-service ambulatory care, the data system capability isn't in place and we ought to worry about our recommendations sounding like an unfunded mandate. One of our recommendations might be for incentives to be provided for the development of information systems. One of our recommendations could help set that aside in the demonstrations.

DR. STOWERS: I agree with a lot of things here and I absolutely agree just because of the simplicity that probably the provider payment differentials is the place to start. And with Joe, that we need to be specific on that.

This whole thing is very exciting. I just wonder if our biggest contribution as a commission might not be to couch this somewhere, in some kind of a strategic plan, and that we really

look at our goals of where we're trying to go with this.

I heard several different goals coming around the table as to what we're trying to accomplish. Are we trying to get everybody up to a benchmark? Or that kind of thing.

I'm okay with the recommendation but I really think it needs to be couched in something that we let Congress know that this is not going to work if we don't work on our information infrastructure, and we don't get our criteria set, and we don't get our case-mix problem solved, that that all has to happen together.

At several conferences we've been at lately, what Mary and Pete are talking about is we've got to accept in Medicine that there's got to be better management systems and that it's not going to be the traditional doctor/ patient relationship or typical hospital things that are happening. So I think that needs to be part of the strategic plan of doing that.

I just would like to see it couched more in that and not on isolated demonstration project that looks at provider differentials but a demonstration project that also looks at some of these other problems and the management systems that might be in that program because there's some really good ones out there.

So I think if we just go after payment differentials in the demonstration project we're going to lose a lot of valuable time and effort. That's kind of where I am.

MS. BURKE: You guys did a terrific job. It is, I think, an enormously important piece that is heading us in the right direction. I have little to add to what has been said, but I wanted to underscore a couple of things.

Let me begin with Ray's points. Pete made, I think, a critical point in his conversation. Congress has a tendency to look at the end result of whatever has occurred, which is often the easiest thing to do. And the failure to look at the inputs and the systems issues here, I think, will lead to a continuation of problems.

And so Ray's point, which was that you need to create a context in which all of this has to be done, that will include looking at the infrastructure and the inputs and the process and procedures, as well as the end result which is the outcome that we measure, will be critical. To fail to do that will have us focus solely on the outcome and that is whether someone does X, Y, or Z, and little attention to the infrastructure that needs to be put in place to achieve that over the long term.

So I think Pete's point, which is that we have to look at both sides of this for equation; Ray's point that you have to create the context so that Congress understands that; I think are going to be critical to whatever is that we do, and I think has to be referenced.

Like Nancy-Ann, I want to underscore and support the points made by Bob and by Joe. And that is the complexity of the politics of this will make or break what it is we try to do. And I can tell you already, that the exercise that will take place to try and anticipate the end result of a demo, that will result in movement of money around the country will be the first thing they ask. Tell me right now what does my district look like? And

what will the impact be? And how much money am I going to lose?

I mean, we went through this when we created DRGs. We went through this when we did M+C and we set rates. It is inevitable, so we may as well anticipate that at the outset.

So to understand that, I think, has to necessarily suggest the kind of detail that Joe raises and what a structured demonstration needs to look at. We, in fact, do not have a good success at either structuring demos nor utilizing the outcomes, nor getting a result that we've put in place any time in our lifetimes.

We've all known demos that have done on -- S-HMOs is a good example -- that have gone on forever with little attention to what we started to ask, where we got with an answer, and whether we did anything with it.

So the detail that Joe suggests is exactly what you need to look at to ensure that the outcome of the process is one that is, in fact, utilized in developing a system.

So I think that looking to Pete's point, create the end and the beginning; Ray's point, we have to create the context of what success will be here and some reasonable expectation; and the kind of details that Joe suggests will be needed to avoid the kind of problem that Bob anticipates we all know will happen.

And I think this is something well worth spending time on at the retreat. I think this has moved us in a terrific direction. I think the whole context of what is best practices? What do we know? Real differences between what the public sector and the private sector are paying for. Our patient mix is very different, attention to that.

But I think we cannot avoid these questions, but we have to create a structure that will get us an end result that is sustainable. The only way you do that is by the kind of investment Pete suggests, which is look at what the inputs look like as well as what the outcomes are going to be. And build consensus around what we all think is success, because that will be what drives this political agenda at the end of the day.

DR. MILLER: Just to say a couple of things. One thing I think is really positive about this is I think we've just hit something that is really important. I think virtually every person commented on this and had a lot to say about it.

I've been taking extensive notes and rather -- because we're over time, I was going to try and track through this and summarize what happened here. But I think we don't really have the time to do that. So what I'll do, when we get out of this, is we'll write an e-mail back to you guys and tell you the major blocks that we'll take up in this chapter.

I just do want to say this. I think we anticipated a lot of what happened here, the idea of trying to be more specific and some of the broader context things. We're coming into this to first say is this even the direction you want to go in or what we want to focus on? And we've heard a lot of help, in terms of trying to frame this and moving forward. And we'll try and lay that out for you and get it back to you.

MR. SMITH: Very briefly, I'm struck, beginning with Pete and Sheila's summing up.

One of the things we ought to talk about at the retreat is whether or not the protocol/process/IT issues, that so many people have talked about so well, necessarily have to be linked to solving all the problems of moving forward on quality.

It seems to me the burden of the case that has been made around this table is we know the importance of this stuff, we know we are lagging. We don't understand enough about why we are lagging, the questions that Nancy-Ann raised.

But it doesn't seem to me we need to hold that conversation and a discussion about how we might move ahead on the protocol/IT front hostage to solving the critical political and design questions that Bob and Joe and others have raised about taking demonstration steps on the incentive and quality question. They aren't necessarily the same question.

DR. NELSON: You want to move on?

I think what I heard was general agreement that this is the direction we want to go. We want to make a good clear statement that Medicare ought to pay for quality. With all of the caveats, don't remove that basic conclusion from what I heard.

MR. HACKBARTH: I agree, Alan. There's a clear consensus on that. I also hear a consensus that we need to begin to experiment with ways to operationalize it. I also heard an acute awareness that there are a number of things that need to come together to achieve the level of quality that we all want for the program for the beneficiaries.

So there's lots of consensus, I think, at the high level and obviously our task, both for the June report and the ensuing months, is to try to get as concrete and detailed on next steps for the program.

Thank you, Karen and Sharon.